MCPS/SEIU Local 500
Sick Leave Bank Grant Request

All ORIGINAL Sick Leave Bank forms MUST be returned to: SEIU Local 500, 901 Russell Ave, Suite 300 Gaithersburg, MD, 20879 or emailed to leavebanks@seiu500.org

Information to be completed by the applicant (please print):

First Name _____ MI _____ Last Name _____ Employee ID _____

Street Address _____ City _____ ST _____ ZIP _____

Home Phone _____ Mobile _____ Work Phone _____

Work Location _____ Job Title _____

Circle one: 10 month or 12 month employee

What is the last full day you were paid Sick Leave? _____
(Refer to page 2 of your paystub)

Dates to be covered by this grant: _____ thru _____

Maximum of 45 days

Is this an extension of Sick Leave Bank benefits? Yes _____ or No _____

Employee Signature _____ Date _____

FOR MCPS/SEIU LOCAL 500 OFFICE USE ONLY

Effective dates of the grant: _____ through _____ Approved or Denied
Maximum of 45 days

Number of work duty days requested : _____

Sick Leave Bank Chairperson _____ Date _____

MCPS Dept. of Human Resources _____ Date _____

MCPS/SEIU Local 500
Sick Leave Bank Physician's Statement

AUTHORIZATION TO RELEASE INFORMATION TO BE COMPLETED BY PATIENT:

I hereby authorize the undersigned physician to release to the Sick Leave Bank Committee any information acquired in the course of my examination and treatment which pertains to the illness or description described below:

_____
PRINT FULL NAME

_____ _____
Patient's Signature Date

TO BE COMPLETED BY PHYSICIAN

This benefit is funded by Montgomery County Public Schools employee donations of sick leave. This is not an insurance benefit or funded by any other means.

FAILURE to provide and complete all fields on this form may result in a delay or denial of the requested grant.

_____ _____
PRINT Physician's Name Phone

_____ _____
Specialty Fax

Diagnosis: _____ **Date of Diagnosis:** _____

Description of illness/condition:

_____

_____

_____

Is the illness or condition that the patient is being treated for a work related injury? Yes or No

Was the patient hospitalized? Yes or No Admission Date: _____ Discharge Date:_____

Did the patient have surgery? Yes or No If yes, Date of Surgery: _____

What is the treatment plan to improve the illness/condition of your patient, so they can return to performing their regular work duties? (Typewritten treatment plan attached to this form is acceptable)
****Note–if employee is seeking continued treatment, please indicate complications, improvements, new prognosis, etc.**

_____

_____

_____

_____

_____

(over)

Has the patient been referred to another physician or specialist? Yes or No If yes, complete below:

Name of Physician _____Specialty _____

If the patient is receiving therapy, such as, physical therapy, chemotherapy, psychiatric therapy, etc., please indicate below:

Type: _____ Frequency: _____

In what way does the illness/condition prevent the employee from performing their job?

_____

_____

_____

_____

For the time the patient is unable to work, the patient can:

Stand or Walk	_____ Not at all	_____ Limited	_____No Restrictions
Sitting Position	_____ Not at all	_____ Limited	_____No Restrictions
Operate Vehicle	_____ Not at all	_____ Limited	_____No Restrictions
Can Lift	_____ Not at all	_____ Limited	_____No Restrictions
Operate Machinery	_____ Not at all	_____ Limited	_____No Restrictions

In your professional opinion:

Do you expect the employee will ever be able to return to return to their current position? Yes or No

If you expect that the employee will be able to return to work performing their current job without restrictions, please provide an estimated date you think this may occur:

_____

(An ESTIMATED DATE is required)

_____

Physician's Signature Date